PATIENT DATA SHEET

InSight **Eyecare**

1. PATIENT DEMOGRAPHICS

First Name	Last Name	Middle Initial	☐ Male ☐ Female		
Address	City	State/Zip Code			
Social Security Number	Birth Date / /	Age	Race	Ethnicity Hisp or Non Hisp	Language
Cell Phone ( )	Work Phone ( )	Home Phone ( )			
Email Address		Marital Status S M D W			

2. EMERGENCY CONTACT

In case of emergency contact:		Relation to patient
Cell Phone ( )	Home Phone ( )	Other Phone (specify)

3. I WAS REFERRED BY ☐ Doctor ☐ Family/Friend ☐ Internet ☐ Self/Drive By ☐ On Base ☐ Media / Other

Please provide name or media source:

4. MY CURRENT EYE DOCTOR IS:

Optometrist / Ophthalmologist	Phone:

5. EMPLOYMENT INFORMATION

Employer / School	PHONE NUMBER
Occupation / Student	Address

6. INSURANCE INFORMATION

Vision Insurance	Medical Insurance	Primary Doctor:
ID#	ID#	Phone #:
Policy Holder:	Policy Holder:	

INSURANCE ACKNOWLEDGEMENT

I hereby assign payment of medical insurance benefits to the above named physician and InSight Eyecare for all services rendered. I understand that I am responsible for all charges whether or not paid by said insurance.
I further understand that I must keep the office updated with current insurance information and any changes that may occur. Should a filed claim be rejected due to inactive coverage, I understand that I will be responsible for all charges due.

I consent to the release of any medical information necessary to process any and all insurance claims.

Signature *Date*

Patient Medical History

(You may be required to update this information every year)

DO NOT LEAVE ANYTHING BLANK. WRITE "NONE" IF ANYTHING DOES NOT APPLY		
Name		**Known Drug Allergies:**
Last Eye Exam:		
Reason for today's visit: routine, second opinion, referred, other		
Past Eye History:		
All Past Surgeries (including medical):		
Medications:		

PATIENT'S MEDICAL HISTORY

- ☐ Diabetes Type I II x ____ yrs
- ☐ Hypertension
- ☐ Heart Disease Pacemaker ____
- ☐ Heart Attack____/Surgery_____
- ☐ Kidney Disease Dialysis ___
- ☐ Arthritis (Rheumatoid or Osteo)
- ☐ High Cholesterol
- ☐ Gastrointestinal Problems _____
- ☐ Acne (ever been on Accutane)
- ☐ Dry Mouth
- ☐ Pregnant or currently Nursing
- ☐ Migraines ever on IMETREX _____
- ☐ Asthma
- ☐ Thyroid Disease Hyper / Hypo
- ☐ Hearing Problems hearing aid _____
- ☐ Depression/Anxiety
- ☐ Cancer type _____
- ☐ Genetic Condition / Syndrome
- ☐ Prostate Condition _____
- ☐ Smoke (How much _____)
- ☐ Alcohol (How much _____)
- ☐ Other _____

Family History

- ☐ Genetic condition / syndrome
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Other _____
  _____

CONTACT LENS WEARERS

What Type and Brand do you wear	
Do you sleep in contacts	Y N
What is your Contact Lens Prescription	
Do you wear Toric contact lenses (have astigmatism)	Y N

PATIENT IS RESPONSABLE FOR CONTACT LENS

FITTING FEE: Int.: _____

Notice of Privacy Practices

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices describes how we will use and disclose protected information and data that we receive or create related to your health care. We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are also required to follow the terms of the Notice currently in effect.

How We May Use and Disclose Health Information About You

We **WILL NOT** use or disclose your health information **WITHOUT** your authorization, except for treatment, payment or healthcare operations.

Notification &Communication of Family:

- You may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition.
- We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

_____YES _____NO

IF YES, THEN ONLY TO THE FOLLOWING PERSON(S):

_____ _____

INFORMATION ABOUT REFRACTIONS &
WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, but they typically do not cover the eye service called "refractions".

What is Refraction?

Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

When Does Insurance NOT Pay for a Refraction?

Most health insurances were not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs and most private policies will not pay for refraction. Almost all insurance payers consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

Who Has Made This Distinction for Insurance Coverage?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore, if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

What Is Our Policy?

A refraction will be performed when medically necessary (typically *this includes all new patients, those presenting with decreased vision, and on a yearly basis thereafter*). However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.

Our fee for the refraction is **$35.00**, and is collected at the time of your visit in addition of any co-payments or deductible due for the medical portion of your exam.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment and deductible are separate from and not included in the refraction fee.

_____ _____

Patient Signature or Signature of person acting on patient's behalf Date

Warranty & Return Policy

LENS WARRANTY – All polycarbonate lenses carry a 1 year, 1-time remake for any scratches. We will replace each lens 1 time at no charge during this 1-year period. Any further replacements during this 1-year period will not be covered. Changes to the lens material or frame will have additional charges.

DOCTOR'S PRESCRIPTION CHANGES – All lenses carry a 60 day doctor's prescription change warranty. If your eye doctor changes your prescription we will exchange your lenses to the updated prescription for no charge within 60 days of your original order date. Any further replacements will be done with an additional charge starting at $50 for single vision and $300 for progressive lenses (no line bi-focal).
This will be an exact exchange only. Changes to the lens material, frame or options selected will have additional charges. **NOTICE**: This warranty applies from the date of purchase, NOT the date glasses were dispensed.

SPECTACLE ADAPTATION – Often a new pair of glasses take some time getting used to. For new wearers, large prescription changes, changes in frame style, and changes in lens material or style we expect you to feel strange for a short period of time in your new glasses. For some patients, especially those with farsightedness, vision might not be clear initially. For this reason, we ask you to wear your new glasses for a least 2 weeks consistently. If you are still having trouble with your new glasses we will re-evaluate them to make sure there is no deviation from your prescription. If the glasses were made according to your prescription, you will need a re-evaluation with your eye doctor. In some cases, 2 weeks is not enough time for adaptation, at which point we ask you to wear them longer. For those new to glasses or new to bifocals/no-line bifocals, several weeks may be required to adapt.

PROGRESSIVE NON-ADAPT – Newer progressive lenses are much easier to adapt to but it still takes some time for your eyes to learn the lens. If a patient has worn the progressives for at least 14 days and cannot adapt, we will exchange the progressive lens for a lined bifocal or trifocal or a single vision lens. Although we will not charge for this exchange, there will not be a refund on any price difference.

SATISFACTION GUARANTEE – We give you 30 days to try out your new eye wear, during which, we will make even exchanges at no cost to make sure you are completely satisfied. If, after 30 days you are still not satisfied, we will continue to try and accommodate your requests although there will be additional charges at that point. **WE DO NOT OFFER FULL REFUNDS**. If, for some reason we are unable to accommodate your needs/requests a partial refund will be given. This amount will vary depending on each individual situation. **NOTICE**: Many insurance plans have specific policy's when using their benefits. We must oblige to their policy for those patients using insurance.

INSURANCE – Please be aware of your vision insurance and the benefits it offers. We will not re-submit your insurance for your exam after you have been seen or after you have placed your glasses order.

REFRACTION FEE – If your exam was performed at InSight EyeCare but your purchased glasses elsewhere there will be a $35 refraction recheck fee if you wish to see our doctor again due to issues you are experiencing with your new glasses.

CONTACT LENS EXAMS – If you wish to have a contact lens exam you have up to 3 months after your initial exam to do so. At that point, the doctor will give you trials to try for a few days. You have 3 months from that date to let us know your satisfaction or dissatisfaction with the contacts. If there is an issue with comfort or vision please let us know within that time frame. If you have an issue after the 3 months you will be subject to another fitting fee ranging from $75 - $95 depending on your prescription.

_____ _____

Patient Signature or Signature of person acting on patient's behalf Date